Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DAVID P LONCARICH MD
7401 SOUTH MAIN STREET
HOUSTON TX 77030

Respondent Name
SEABRIGHT INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-12-0324-01

MFDR Date Received
September 30, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was processed and CPT code 28730 denied as being included in the value of another procedure CPT code 28465. However per Medicare NCCI edit these are not bundled. CPT code 28465 effects the tarsal bone fracture treatment. Whereas 28730 effects the fusion of mid tarsal joints fusion. These are two separate areas and issues and are documented in the op report. CPT code 28465 affects the actual bone whereas the 28730 affects the joints hence these cannot be bundled. Nor does NCCI edit bundle these. We are respectfully requesting you reprocess this claim and pay accordingly."

Amount in Dispute: $856.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $2035.00 for the service underlying the disputed charge, and submits it is entitled to reimbursement in the amount of $856.11. The carrier maintains that no reimbursement is due for the treatment rendered. The service (billed using CPT Code 28730) is included with a separate procedure that has already been billed and reimbursed for this same date of service. The requestor is engaging in unbundling, and additional reimbursement is not due for unbundled services."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2011	28730	$856.11	$856.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 663 – Reimbursement has been calculated according to the state fee schedule guidelines
   - 850-048 – Based upon clinical review by our onsite medical staff, this service/procedure is being denied as inclusive of another service/procedure billed on this day
   - 850-065 – After reviewing your reconsideration, it has been determined based upon clinical review by our onsite medical staff, the original decision stands and no additional allowance is being recommended.

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 28730 rendered on March 22, 2011. The division completed NCCI edits to identify edit conflicts that would affect reimbursement. The division finds that no edit conflicts were identified as a result, the disputed service bill be reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).
2. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   Review of the submitted documentation finds that the requestor is entitled to reimbursement for CPT code 28730. The MAR reimbursement is $1,712.27, the requestor seeks reimbursement in the amount of $856.11, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $856.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $856.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		November 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.